April 19, 2010

Honorable Kevin R. Huennekens
United States Bankruptcy Judge
United States Bankruptcy Court
701 East Broad Street – Room 4000
Richmond, VA 23219

RE: Circuit City Stores, Inc., et al., Case No. 08-35653, Claim No. 14139 – Disallowance of Certain No Liability Human Resource Claims

Honorable Huennekens:

This letter is response to the objection filed by the lawyers representing Circuit City Stores, Inc. in their bankruptcy proceedings. They are asserting that certain benefit plans sponsored by Circuit City Stores, Inc. were not benefit plans falling under ERISA and that the plans were amended and that no plan assets remain.

I was the benefits manager for the health and welfare plans at the time of the bankruptcy announcement and was not kept on the stay back team. I have knowledge of the amount of the excess funds in the plans in addition to the approximate number of participants which is how I calculated the dollar amount of my claim. I have earned the Certified Employee Benefits Specialist certification from the International Foundation of Employee Benefit Plans in conjunction with the Wharton School of Business.

The plans in which I am seeking reimbursement were plans sponsored by Circuit City Stores, Inc. The company did not contribute to the cost of these plans and these plans in question were fully funded by employee contributions. To keep the excess money contributed by employees and forwarding to creditors and paying lawyer fees is unjust. The participants should get a refund for their over-contributions and should not be punished by the unfortunate circumstances that unfolded.

Circuit City Stores, Inc. failed in their fiduciary obligations. Under ERISA, a Summary of Material Modification (SMM) apprises participants and beneficiaries of material changes to the plan or to the information required to be in the Summary Plan Description. The SMM or an updated SPD for a group health plan must be furnished automatically to participants within 210 days after the end of the plan year in which such material change was adopted. However, if the changes to the plan or changes to the required information in the SPD result in a material reduction in covered services or benefits, then the SMM must be distributed no later than 60 days from the date the change was adopted. A material reduction is any plan change that eliminates benefits, reduces benefits payable, increases premiums, deductibles, coinsurance or co-payments, reduces the service area covered by an HMO, or establishes new conditions or requirements (such as pre-authorization) for obtaining services or benefits. Circuit City did not at any time provide an SMM even though I had asked the question many times prior to my departure. I was advised that we were not supposed to spend money on communications of any sort.

The Dependent Care Spending Account (DCSA) was modified and the Summary Plan Description written in December of 2008 with an effective date of March 1, 2009 is the most

recent and communicated Plan Document. The plan was established and maintained by Circuit City Stores, Inc. for the exclusive benefit of the plan participants and with Circuit City Stores, Inc. paying the administrative costs of the plan. The most recent plan document states that you have 90 days from the date of the end of the Plan Year to submit claims for reimbursement – not 90 days from the date of termination. Furthermore, forfeitures are assets of the company but can only be used to offset administrative expenses for the plan in question. Since the plan is terminated and there are no more administrative fees to pay, the excess should be returned to the participants. I would also like to note that several times since 2001, the benefits team had asked ERISA counsel at Williams Mullen and McGuireWoods throughout the years whether we could donate the forfeited funds to a charity and were told on each and every occasion that we could only continue to hold the excess funds to pay administrative fees or give the money back to the participants in an equitable manner. I find it interesting that this same advice is now being objected to.

Those participants that were denied FSA benefits but requested reimbursement prior to May 31, 2009, should also be paid benefits because they followed the procedures outlined in the Summary Plan Description and were not given an SMM to know that the plan was being terminated and that claims had to be filed before that date.

A Summary Annual Report (SAR) is also supposed to be sent yearly to participants. Circuit City Stores, Inc. failed to send the SAR for Plan Years 2008 and 2009. Circuit City Stores, Inc. willfully violated ERISA's reporting and disclosure requirements.

It was also stated in the objection that the Vision Care Plan and the Health Care Spending Account plans were amended to permit the use of any remaining plan assets to provide benefits or pay expenses under one or more of the other employee benefit plans maintained by the debtor. An ERISA plan is one that is set up exclusively for the benefit of the participants in that plan. Each plan is separate ERISA plan and documented by separate plan numbers and cannot be combined even with an amendment. I was not a participant in the health or dental plans so my excess contributions cannot be used to pay expenses for benefit plan(s) that I was not enrolled in. Also, an amendment of this type cannot be made after an amendment was made to terminate the plan(s). In addition, there was a reserve on Circuit City's books in excess of $1,000,000 (Incurred But Not Reported or IBNR) to cover medical and dental claims should the plans ever be terminated. This number should have been adjusted upward in February of 2009 when the vendors were notified of the March 31 termination dates and adjustments made accordingly.

I would also like to note the definition of a Prohibited party under ERISA. Prohibited parties (called parties in interest) include the employer, the union, plan fiduciaries, service providers, and statutorily-defined owners, officers, and relatives of parties in interest. There is a long list of prohibitions including those that relate to fiduciaries who use the plan's assets in their own interest or who act on both sides of a transaction involving a plan. Fiduciaries cannot receive money or any other consideration for their personal account from any party doing business with the plan related to that business. In this case those that are denying the payment of this type of claim are acting on both sides of the transaction and stand to gain from denying payment. They will be rewarded by the number and the dollar amount of the claims that are denied in the form of a bonus.

By denying my claim, there are several ERISA civil violations that are occurring including but not limited to:

- Failing to operate the plan prudently and for the exclusive benefit of participants.
- Using plan assets to benefit certain related parties to the plan, including the plan administrator, the plan sponsor, and parties related to these individuals.
- Failing to follow the terms of the plan
- Taking any adverse action against an individual for exercising his or her rights under the plan (e.g., being fired, fined, or otherwise being discriminated against).
- Willfully violating ERISA's reporting and disclosure requirements.

I would also like to assert that my HIPAA Privacy rights were violated by Circuit City Stores, Inc. and their counsel when they released my name, address and enrollment information in the Debtors' Seventieth Omnibus Objection to Claims. They did not have my authorization to disclose this information to the other claimants.

I have enclosed a copy of my original claim including the SPD authored by Write On Target in Dayton, OH in December of 2008 for Circuit City's open enrollment campaign in January of 2009 prior to the bankruptcy announcement. Their telephone number is 937-436-4565.

I respectfully request that the debtors and their attorneys reconsider their denial and grant my claim for reimbursement. If I need to be present April 29 for the court proceeding, I will do my best to attend however I am expecting a child around this timeframe.

Sincerely,

Jaime Stack
3107 Old Brookewood Way
Richmond, VA 23233
Ph: 804.929.1632

Cc: Gregg M. Galardi, Esq., Skadden, Arps, Slate, Meagher & Flom, LLP, via Fedex
Ian S. Fredericks, Esq., Skadden, Arps, Slate, Meagher & Flom, LLP, Via Fedex
Chris L. Dickerson, Esq., Skadden, Arps, Slate, Meagher & Flom, LLP, via Fedex
Dion W. Hays, McGuireWoods, LLP, via hand delivery
Douglas M. Foley, McGuireWoods, LLP, via hand delivery

Enclosures

(10-4200)

June 29, 2009

Circuit City Stores, Inc., et al.

Claims Processing Dept.

Kurtzman Carson Consultants LLC

2335 Alaska Avenue

El Segundo, CA 90245

To Whom it May Concern:

I am submitting an Administrative Expense Request in the amount of $263.10 against Circuit City Stores, Inc. (3875). I was a participant in certain benefit plans sponsored by Circuit City Stores, Inc. These certain benefit plans, specifically the Vision Care Plan, Health Care Spending Account Plan and Dependent Care Spending Account Plan, were fully funded by participant contributions. Circuit City did not contribute the cost of these plans and therefore the money should be returned to the participants in a fair and equitable manner.

The Vision Care Plan was overfunded with Active and COBRA participant contributions that were to be used for the sole benefit of the participants. There were approximately 5,500 participants in the Plan on March 31, 2009, with approximately $304,790 in excess contributions. I am submitting a claim for $55.42 which is an approximate estimation of my share of the excess contributions as they should be redistributed to the participants since the company did not contribute to the cost of this employee benefit plan.

The Dependent Care Spending Account Plan contains forfeitures from the plan's inception that have not been distributed to the participants. All administrative fees associated with this plan have been paid. This employee benefit plan was created for the sole benefit of the participants with no company contributions, and since no additional administrative fees are due, I am submitting a claim for $139.16 which is the approximate distribution to the participants based on an average of 200 participants and forfeitures of $27,832.

The Health Care Spending Account Plan contains forfeitures from the plan's inception that have not been distributed to the participants. All administrative fees associated with this plan have been paid. This employee benefit plan was created for the sole benefit of the participants, with no company contributions, and since no additional administrative fees are due, I am submitting a claim for $68.52 which is the approximate distribution to the participants based on an average of 800 participants and forfeitures of $54,819.

Sincerely,

Jaime Stack

Jaime Stack

3107 Old Brookewood Way

Richmond, VA 23233

804-364-8995

Emplid: 10144784

This claim is being filed for Administrative Expenses as ordered by the United States Bankruptcy Court on May 15, 2009.

Following the bankruptcy petition date, Circuit City terminated the following benefit plans:

Dependent Care Spending Account
Health Care Spending Account
Vision Care Plan

Each of these plans were 100% employee funded and funds should be distributed among plan participants.

The basis of claim is calculated as follows:

Plan Name	Plan Balance	Est. # of Plan Participants	Amount/Participant
Vision Care Plan	304,790.00	5,500	55.42
Health Care Spending Account	54,819.00	800	68.52
Dependent Care Spending Account	27,832.00	200	139.16
	390,441.00		263.10

Administrative Information

Plan Information

PLAN NAME	FUNDING	CONTRIBUTIONS
Circuit City Stores, Inc. Health Care Plan Plan #: 503	Self-funded*	Company & Associates
Circuit City Stores, Inc. Traditional Dental Care Plan Plan #: 501	Self-funded*	Company & Associates
Circuit City Stores, Inc. Vision Care Plan Plan #: 512	Self-funded*	Associates
Circuit City Stores, Inc. Health Care Spending Account Plan	Self-funded*	Associates
Circuit City Stores, Inc. Dependent Care Spending Account Plan	Self-funded*	Associates
Circuit City Stores, Inc. Short Term Disability Plan	Self-funded*	Company
Circuit City Stores, Inc. Long Term Disability Plan Plan #: 502 60% Long Term Disability Policy No. – 810018-15-00001 40% Long Term Disability Policy No. – 810018-16-00002	Insured through Aetna Life Insurance Company	Associates
Circuit City Stores, Inc. Life Insurance Plan Plan #: 510 Life Plan Policy No. 810018-13-00001 AD&D Policy No. 810018-14-00001	Insured through Aetna Life Insurance Company	Company & Associates

**Self- funded means that Circuit City Stores, Inc pays all benefits from its general assets. There is no insurance contract, trust fund, or other method where funds are set aside to provide these benefits.*

Agent for Service of Legal Process:
Circuit City Stores, Inc.
Attn: Corporate Secretary
9950 Mayland Drive
Richmond, VA 23233
Phone: (804) 527-4000

Plan Sponsor and Plan Administrator:
Circuit City Stores, Inc.
9950 Mayland Drive
Richmond, VA 23233
Phone: (804) 527-4000

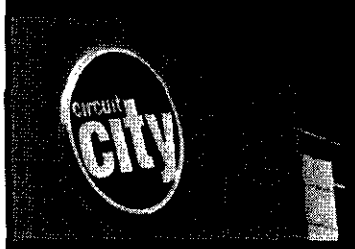
Associate Service Center:
Hewitt Associates
Associate Service Center
P.O. Box 563986
Charlotte, NC 28256-3986
Phone: (800) 288-6353

Type of Administration: Circuit City Stores, Inc. has the authority to control and manage the operation and administration of all Plans listed above. For certain Plans, Circuit City Stores, Inc. may delegate administrative responsibilities to a third party, such as an insurance company or other service provider, or to an Associate or committee of Associates. Please see the appropriate section of this booklet for specific administrative information about a particular Plan.

Employer Identification Number (EIN): 54-0493875

Plan Year: The financial records of the Plans are kept on a March 1 through February 28/29 Plan Year. The Plan Year ends each February 28/29.

Other: In the event that relevant facts about the Associate's enrollment are inaccurate or administrative errors occur, an adjustment will be made. Additional contributions from the Participant or a refund to the Participant may be required to correct the situation. In any event, the terms of each Plan and/or Company policy will prevail. The benefits described in this booklet do not constitute or imply employment contracts or any other contractual obligations between the Company and its Associates and/or other individuals eligible to participate in the Plans. Circuit City Stores, Inc. retains the right to modify or terminate any of the Plans at any time.



2009 Summary Plan Description and Benefits Book

Health and Welfare Plans

Effective March 1, 2009

Table of Contents

Introduction

This guide includes details of all the benefits, programs and discounts Circuit City Stores, Inc. offers to its Associates. You are not required to enroll in all of the benefit plans (the "Plans"); however, we encourage you to consider the ways each Plan can help you manage your wellbeing and your finances.

The health & welfare Plan(s) are an important part of your total rewards package. We urge you to read this information carefully and share it with your family. This guide should serve as your reference tool and should be filed for future reference.

The beginning of this guide provides general information applicable to each of the Plans described. Be sure to read the general information along with the relevant sections for a particular Plan when you are trying to understand your benefits, rights, and responsibilities under that Plan.

These Plans are a valuable source of security for you and your Dependents. To determine which Plans are best for you, consider the following:

- What type of Associate are you? Full-time, Part-time or Temporary? Hourly or Salaried?
- Are you eligible to participate in the Plan(s)?
- Are your Dependents eligible to participate in the Plan(s)?
- How and when should you enroll in the Plan(s)?

This guide is divided into sections for each benefit Plan. Unless the context clearly indicates otherwise:

- "you" refers to the Associate
- "the Plan" and "our Plan" refer to the particular Plan within a section
- "Participant" refers to enrolled members of the particular Plan, including eligible Associates and their Dependents, when applicable

Throughout this guide, glossary terms begin with a capital letter. (These terms are defined at the back of the guide.) Shaded boxes highlight important Plan information.

Some Plans must adhere to certain state and/or federal laws. Because the laws may change, the Plan will be administered according to the new law regardless of the terms of the SPD.

If you have questions about a particular Plan, call the Associate Service Center at (800) 288-6353.

The guide includes summaries of some of the important features of the Plans and do not necessarily describe every detail of each Plan. Should there be any discrepancies between the information in this booklet and the official Plan documents, the provisions of the Plan documents will govern. You may review these Plan documents by contacting the Plan administrator.

It is very important to keep *YOUR* contact information up to date!
Update your name and other personal information by logging on to www.mycircuitcityhr.com or by calling the Associate Service Center at (800) 288-6353.

Refer to the Standard Operating Policy section of www.ccity.com for details about Associate Leave, Time Away, Matching Gifts, and Associate Purchases, etc.

Administrative Information

Plan Information

Plan Name	Funding	Contributions
Circuit City Stores, Inc. Health Care Plan Plan #: 503	Self-funded*	Company & Associates
Circuit City Stores, Inc. Traditional Dental Care Plan Plan #: 501	Self-funded*	Company & Associates
Circuit City Stores, Inc. Vision Care Plan Plan #: 512	Self-funded*	Associates
Circuit City Stores, Inc. Health Care Spending Account Plan	Self-funded*	Associates
Circuit City Stores, Inc. Dependent Care Spending Account Plan	Self-funded*	Associates
Circuit City Stores, Inc. Short Term Disability Plan	*Self-funded**	*Company*
Circuit City Stores, Inc. Long Term Disability Plan Plan #: 502 60% Long Term Disability Policy No. – 810018-15-00001 40% Long Term Disability Policy No. – 810018-16-00002	*Insured through Aetna Life* Insurance Company	Associates
Circuit City Stores, Inc. Life Insurance Plan Plan #: 510 Life Plan Policy No. 810018-13-00001 AD&D Policy No. 810018-14-00001	Insured through Aetna Life Insurance Company	*Company & Associates*

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Benefits Contact Information

Associate Service Center	Associate Service Center (800) 288-6353 email: circuitcity.hrservices@hewitt.com
Benefits Enrollment • Health & Insurance • Annual Enrollment • Qualified Family Status Changes	Associate Service Center (800) 288-6353, select "Health & Insurance" option www.mycircuitcityhr.com, then *My Circuit City Benefits* email: circuitcity.hrservices@hewitt.com
Leave Administration • Short Term Disability • Leave of Absence	Associate Service Center (800) 288-6353, select "Leave Administration" option Fax: (281) 298-0845 email: circuitcity.hrservices@hewitt.com Circuit City P.O. Box 563986 Charlotte, NC 28256-3986
Death Notification	Associate Service Center (800) 288-6353, select "Other" option Fax: (281) 298-0845 email: circuitcity.hrservices@hewitt.com
Medical Plan (Empire)	Empire BlueCross BlueShield PPO (800) 675-1277 www.empireblue.com/circuitcity
Medical Plan (Kaiser) For Hawaii Associates	Kaiser Permanente Added Choice POS (800) 238-5742 www.kaiserpermanente.org/hawaii
Behavioral Health Program*	Anthem Behavioral Health (800) 675-1277 www.empireblue.com/circuitcity
Prescription Drug Plan*	Medco Health Solutions (800) 988-4105 www.medcohealth.com
LifeWorks® Assistance Program (Employee Assistance Program)	LifeWorks® (888) 267-8126 www.lifeworks.com, user id: circuitcity; password: lifeworks
Traditional Dental Care Plan	Aetna (800) 843-3661 www.aetna.com
Vision Care Plan	VSP (800) 877-7195 www.vsp.com
Health Care Spending Account **Dependent Care Spending Account**	*Your Spending Account* (800) 288-6353, select "Health & Insurance" option www.mycircuitcityhr.com, then *My Circuit City Benefits* and select *Your Spending Account*
Long Term Disability Insurance	Aetna (877) 465-0424 www.aetna.com/group/circuitcity
Life and Accidental Death & Dismemberment (AD&D) Insurance	Aetna (800) 523-5065 www.aetna.com/group/circuitcity
Business Travel Accident	Zurich American Insurance Company (800) 263-0261 www.zurichna.com/travelassist

**For Participants in the Empire Medical Plan*

The Associate Service Center at Hewitt Associates

Circuit City Stores, Inc., as Plan Sponsor, has retained the services of Hewitt Associates to assist with certain administrative functions. Hewitt Associates performs these services under the name "Associate Service Center."

General information about your benefits is available by accessing the *My Circuit City Benefits* website or by calling the Associate Service Center. The website is available 24 hours a day, seven days a week. Phone service representatives are available weekdays, excluding holidays, from 8:00 a.m. to 6:00 p.m., Eastern Time.

Contacting the Associate Service Center
There are two ways to contact the Associate Service Center:

- By Computer: *My Circuit City Benefits* website
  - Log on to www.mycircuitcityhr.com
  - Click on *My Circuit City Benefits*

- By Toll-free Telephone: (800) 288-6353
  - *You can call the Associate Service Center and access the voice response system. Follow the instructions to* access the correct department.

Eligibility and Enrollment

Associate Eligibility

Eligibility for Circuit City's benefits plans is primarily determined by your employment status: Full-time, Part-time, or Temporary. Eligible Associates are automatically enrolled in the Short Term Disability Plan, Employee Assistance Program and Basic Life Insurance. All other Plans require you to complete an electronic enrollment process to begin participation. If you do not have access to a computer, contact the Associate Service Center at (800) 288-6353 and select the "Health and Insurance" option.

Special Note for Part-time Associates: If you do not work enough hours to pay for your bi-weekly deductions for two consecutive pay cycles, your coverage will be dropped.

Dependent Eligibility

Eligible Dependents may be enrolled in or dropped from coverage for the Medical, Dental Care and Vision Care Plans at the same time as eligible Associates. Eligible Dependents generally can include your legal spouse, children who can be claimed as your tax dependents and your domestic partner, subject to certain age and other limitations listed in the *definition of "Dependent" under the glossary section.*

Participants who no longer qualify for coverage will be dropped from the Plan(s) automatically.

Eligibility and Enrollment Requirements

The following table highlights who is eligible to participate, the eligibility dates and how and when to enroll in the Plans.

Plan	Eligible Associates and Eligibility Dates	When to Complete the On-line Enrollment Process
Medical Plan (Empire)	• Regular Full-time Associates – first of month after completing one calendar month of service (spouse, domestic partner and Dependent children are also eligible)	• Regular Full-time Associates – within 30 days after your date of hire, during annual enrollment or upon a Qualified Family Status Change

Medical Plan (Kaiser – Hawaii Associates Only)	• All Hawaii Associates – first of month after completing one calendar month of service
	• Regular Full-time Associates only – spouse and Dependent children are also eligible
		• All eligible Associates – complete the on-line enrollment process and HC-5 Form:
		  • within 30 days after your date of hire
		  • upon/after a Qualified Family Status Change
		  • during annual enrollment

Traditional Dental Care Plan	• Regular Full-time Associates – first of month after completing one calendar month of service (spouse, domestic partner and Dependent children are also eligible) • Regular Part-time Associates – first of the month after completing one year of continuous service	• Regular Full-time and Part-time Associates – within 30 days after your date of hire • All eligible Associates – during annual enrollment or upon/after a Qualified Family Status Change
Vision Care Plan	• Regular Full-time Associates – first of month after completing one calendar month of service (spouse, domestic partner and Dependent children are also eligible) • Regular Part-time Associates – first of the month after completing one year of continuous service	• Regular Full-time and Part-time Associates – within 30 days after your date of hire • All eligible Associates – during annual enrollment or upon/after a Qualified Family Status Change
Health Care Spending Account	• Regular Full-time Associates – first of month after completing one calendar month of service • Regular Part-time Associates – first of month after completing one year of continuous service	• Regular Full-time and Part-time Associates – within 30 days after your date of hire • All eligible Associates – during annual enrollment (must enroll/re-enroll each annual enrollment) or upon/after a Qualified Family Status Change
Dependent Care Spending Account	• Regular Full-time Associates – first of month after completing one calendar month of service • Regular Part-time Associates – first of month after completing one year of continuous service	• Regular Full-time and Part-time Associates – within 30 days after your date of hire • All eligible Associates – during annual enrollment (must enroll/re-enroll each annual enrollment) or upon/after a Qualified Family Status Change
Short Term Disability	• Regular Full-time Salaried Associates – date of hire • Regular Full-time Hourly Associates – first of the month after completing one year of continuous service	No enrollment necessary – Automatically enrolled when eligible for leave component. Paperwork submission required for those eligible for pay while on leave.
Long Term Disability	• Regular Full-time Associates – first of month after completing one calendar month of service • Must be Actively at Work for coverage to become effective	• Regular Full-time Associates – at any time Note: Enrollment in Long Term Disability after initial 30-day enrollment window will require Evidence of Insurability (EOI) and approval from the insurance carrier

PLAN	ELIGIBLE ASSOCIATES AND ELIGIBILITY DATES	WHEN TO COMPLETE THE ON-LINE ENROLLMENT PROCESS
Basic Life Insurance	• Regular Full-time Associates – first of month after completing one calendar month of service • Regular Part-time Associates – first of month after completing one year of continuous service • Must be Actively at Work for coverage to become effective	No enrollment necessary (automatically enrolled when eligible)
Optional AD&D	• Regular Full-time Associates – first of month after completing one calendar month of service • Regular Part-time Associates – first of month after completing one year of continuous service • Must be Actively at Work for coverage to become effective.	• All eligible Associates – at any time
Supplemental Life Insurance	• Regular Full-time Associates – first of month after completing one calendar month of service • Regular Part-time Associates – first of month after completing one year of continuous service • Must be Actively at Work for coverage to become effective.	• All eligible Associates – at any time Note: Enrollment in Supplemental Life after initial 30-day enrollment window will require Evidence of Insurability (EOI) and approval from the insurance carrier
Spousal Life Insurance	• Regular Full-time Associates – first of month after completing one calendar month of service (spouse and domestic partner eligible) • Regular Part-time Associates – first of month after completing one year of continuous service	• All eligible Associates – at anytime Note: Enrollment in Spousal Life after initial 30-day enrollment window will require Evidence of Insurability (EOI) and approval from the insurance carrier. Enrollment in Spousal Life for coverage over $50,000 will also require EOI
Child Life Insurance	• Regular Full-time Associates – first of month after completing one calendar month of service (Dependent children eligible) • Regular Part-time Associates – first of month after completing one year of continuous service	• All eligible Associates – at anytime
Employee Assistance Program	• All Associates – date of hire	No enrollment necessary (automatically enrolled when eligible)

Note:

- If you are required to submit Evidence of Insurability (EOI) or obtain approval from the insurance carrier for Long Term Disability enrollment and/or any Life Insurance Plan, the carrier reserves the right to deny your enrollment.
- Enrollment in a Plan does not guarantee that you will receive benefits, payments or reimbursements.

If you have questions about eligibility and enrollment guidelines, call the Associate Service Center at (800) 288-6353.

Enrollment

To enroll on-line, go to www.mycircuitcityhr.com website, then click the *My Circuit City Benefits* link. If you do not have access to the Internet or for some other reason cannot enroll on-line, contact the Associate Service Center at (800) 288-6353. Your first paycheck after the effective date of coverage should reflect appropriate payroll deductions. If it does not, call the Associate Service Center at (800) 288-6353 for assistance.

Enrollment Restrictions

Participants who enroll due to a Qualified Family Status Change may be subject to Pre-existing Condition exclusions and may have to provide Evidence of Insurability (EOI) to enroll in certain Plans. Note additional restrictions listed below.

- If you and/or your Dependents do not enroll in the medical plan when first eligible or have a break in previous coverage for more than 63 days, Pre-existing Condition exclusions may apply.
- Dependent children may be enrolled in Child Life Insurance until the end of the calendar month in which they reach age 23, at which time they may convert their coverage to an individual policy.

Employment Status Changes

There are several factors that can affect your level of coverage and/or eligibility. You and/or your Dependents may gain or lose coverage due to an employment status change or a Qualified Family Status Change.

When you are Rehired to the Company after a break in service, the Associate Service Center will send you notification of how the change affects your benefits. If the length of your break in service is greater than 30 days, you have to reenroll in the benefit Plans.

When you change your employment status to Full-time, Part-time or Temporary, you and your Dependent's eligibility will depend on your new employment status and your service prior to the change. Dependent coverage will be dropped when your status changes from Full-time to Part-time or Temporary.

The table below lists the general eligibility and enrollment guidelines for Associate employment status changes.

Status Change	Impact on Benefits
Rehired • Actively at Work • Break in service greater than 30 days	• You can enroll according to the eligibility and enrollment requirements for each plan, depending on whether you are Full-time, Part-time or Temporary • Prior service does not apply
Reinstated and previously enrolled • Actively at Work • Break in service 30 days or less	• Your previous benefit elections will be automatically Reinstated, as long as you still meet the eligibility requirements • You cannot make changes to your previous elections until annual enrollment or if you experience a Qualified Family Status Change • Prior service will apply
Full-time to Part-time	• Unless the Plan offers coverage to Part-time Associates and you meet the Plan's eligibility requirements, your coverage will end on the last day of the month in which your status change occurs • If you are enrolled in a Plan that offers coverage for Part-time Associates, then your dependents will be dropped from your coverage the last day of the month
Part-time to Full-time	• You can enroll in all of the benefit plans according to the eligibility and enrollment requirements for Full-time Associates within 30 days of the event • Prior service will apply

Changing Your Election

Internal Revenue Service (IRS) regulations and Plan rules restrict you from changing your Plan coverage during the Plan Year. As a result, in most cases, the coverage level and benefit elections you choose:

- When you are a newly eligible Associate, remain in effect for the remainder of that Plan Year; and
- During each annual enrollment period, become effective on March 1 of the next Plan Year and remain in effect until February 28/29 of that Plan Year.

Under limited circumstances, however, you may be permitted to change your elections if, after you have made your election, certain "Qualified Family Status Change" events occur (as described below). In addition, if you have elected the "No Coverage" option, or if you have a new Dependent through marriage, birth or adoption, you may be allowed to enroll during the year under certain circumstances described below in the "Special Enrollment Rights" section.

If you want to change your election for any reason other than those permitted under Plan rules, you will have to wait until the next annual enrollment period to make a change effective for the next Plan Year except for certain limited circumstances, described below, under which you may be able to elect coverage outside of the Plan on an after-tax basis. If you believe you have experienced (or will experience) an event that may allow you to change your election, you should contact the Associate Service Center.

Qualified Family Status Change

You may be permitted to change a benefit election if after your election you experience a "Qualified Family Status Change" as determined by the Plan administrator, subject to IRS regulations and Plan rules. Qualified Family Status Changes are generally described below. Any change in your elections must be consistent with the event as determined by the Plan administrator. You must notify the Associate Service Center and change your election after the date on which the Qualified Family Status Change occurred and prior to the end of the Plan Year in which the original election relates. Keep in mind that in all events you can change benefit election for an upcoming Plan Year during the annual enrollment period.

A change in election following a Qualified Family Status Change will generally be effective on a prospective basis only. However, in the case of an event that is the birth or adoption of a child, you may be able to add coverage for yourself or a Dependent retroactive to the date of the birth, adoption or placement for adoption if you make your election within 30 days after the event, as described in the "Special Enrollment Rights" section.

Qualified Family Status Change events include:

- Change in your legal marital status;
- Change in the number of your Dependents;
- Change in employment status for you, your spouse, your domestic partner or your Dependent child that results in a change in eligibility for benefits;
- You lose coverage under your parent's plan;
- Your child or domestic partner satisfies (or ceases to satisfy) Dependent eligibility requirements;
- The start or end of adoption proceedings that results in the placement of the child; or
- Change in your residence to the state of Hawaii or Puerto Rico.

Your election change becomes effective on the appropriate date shown below (subject to the rule that the new election be consistent with the Qualified Family Status Change):

- New spouse of covered employee: first of the month following the date of your marriage and after you notify the Associate Service Center and make your new election

- Newborn: date of birth if the election is made within 30 days after birth; otherwise, first of the month following the date of birth and after you notify the Associate Service Center and make your new election (subject to your limited right to elect retroactive coverage for the child on an after-tax basis as described below)
- Legal guardianship: first of the month following the date of custody or petition for guardianship, whichever occurs later and after you notify the Associate Service Center and make your new election
- Legal adoption: date the child is placed in the residence of the covered associate, if the election is made within 30 days after the event; otherwise, first of the month following the date of the placement and after you notify the Associate Service Center and make your new election (subject to your limited right to elect retroactive coverage for the child on an after-tax basis as described below)
- Domestic partner: the first of the month following the date you have satisfied all of the requirements for domestic partner status (including living together for 12 consecutive months), and after you notify the Associate Service Center and make your new election

To ensure that the correct coverage level and enrolled Dependent information are in effect for you at all times, you must inform the Associate Service Center of any of the following events:

- Divorce from your spouse,
- Annulment of your marriage,
- Legal separation from your spouse or cessation of domestic partner status,
- Death of a covered Dependent (spouse, domestic partner or child), and
- The date on which a covered child or domestic partner is no longer considered to be an eligible Dependent.

Dependent Child Regains Eligibility for Coverage

If your Dependent child regains eligibility for coverage, you may change your coverage level and your benefit elections consistent with the change. Coverage for your eligible Dependent child becomes effective on the first of the month following the date your child regains eligibility under the Plan and after you notify the Associate Service Center and make your new election to cover the child.

Transfers/Relocation

You may be able to change your medical plan elections if you move to Hawaii or Puerto Rico, or if you move to the mainland from Hawaii or Puerto Rico. The Associate Service Center will provide you with information about your new options.

Employment Changes

If the change in status event that affects you, your spouse, your domestic partner or a Dependent child relates to termination, start of employment or a change in employment status, you may be able to change your coverage level and/or benefit elections to the extent the change is consistent with the event. Any allowable change becomes effective the first of the month after the applicable event has occurred and after you notify the Associate Service Center and make your new election. Refer to the "Employment Status Changes" section earlier in this booklet.

Certain Other Events

Certain other events may also occur that allow you to change your benefit elections. For example, you may be permitted to make certain changes due to taking a leave of absence under the Family and Medical Leave Act (FMLA) or because of qualifying military service, certain court orders (such as qualified medical child support orders - QMSCOs) or entitlement (or loss of entitlement) to Medicare or Medicaid. In addition, if a significant change occurs in your spouse's or your domestic partner's health care coverage under another employer's plan, you may be able to change your elections. Any change to your elections must be consistent with the type of event you have experienced and will become effective the first of the month after the event has occurred and after you notify the Associate Service Center and make your new election.

Special Enrollment Rights

If you decline coverage or if you gain a new dependent, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with special enrollment rights in certain cases if you had declined coverage for the year, or if you gain a new dependent through marriage, birth or adoption. If you declined coverage for yourself or your Dependents (including your spouse or your domestic partner) because you or your Dependent have other health care coverage, you may be able to enroll yourself or your Dependents in the Plan if your other coverage ends. You must contact the Associate Service Center and make your enrollment election within 30 days of the date the other coverage ends. In addition, if you gain a new Dependent as a result of marriage, domestic partner eligibility, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents if you request enrollment through the Associate Service Center within 30 days after the marriage, domestic partner eligibility, birth, adoption or placement for adoption. In the case of enrolling after a birth or adoption, the new coverage will be retroactive to the date of birth or placement for adoption if you make the election within the 30-day period. You may also make new elections consistent with the Qualified Family Status Change rules described above.

After-tax Retroactive Coverage for a New Child Following Birth or Adoption

If you fail to make a coverage election under the Plan within 30 days following a birth or placement for adoption, you may nevertheless elect to cover the child retroactive to the birth or placement for adoption, provided that you make the election no later than 12 months after the birth/adoption. However, you will have to pay your share of the cost for such coverage on an after-tax basis. Whether the prospective coverage for the child will be pre-tax or after-tax will depend on when you elect to add the child. If you do so by no later than the end of the annual enrollment period following the birth/adoption, then the prospective coverage will generally be provided on a pre-tax basis. If you wait until after the annual enrollment period (but no later than 12 months after the birth/adoption), then your share of the cost of coverage will generally be on an after-tax basis until the beginning of the next Plan Year.

Costs and Contributions

Benefits are a valuable part of Circuit City's total compensation package. Circuit City pays a portion or, in some cases, all of the costs for the Plans. Costs are subject to change. The chart below outlines who contributes to each Plan.

PLAN	CIRCUIT CITY PAYS	YOU PAY
Medical Plan	Partial	Partial
Dental Care Plan	Partial	Partial
Vision Care Plan		100%
Health Care Spending Account		100%
Dependent Care Spending Account		100%
Short Term Disability	100%	
Long Term Disability		100%
Basic Life Insurance	100%	
Supplemental Life Insurance		100%
Spousal and Child Life Insurance		100%
Accidental Death & Dismemberment		100%

Monthly contributions are automatically deducted bi-weekly from participating Associates' paychecks. The amount of the deduction varies according to each Plan's provisions and your coverage level. Visit www.mycircuitcityhr.com for a list of current monthly Associate contributions.

Pre-tax Contributions

Participants enrolled in the Medical, Dental Care, Vision Care, Health Care Spending Account and Dependent Care Spending Account Plans generally make contributions on a pre-tax basis. This method of contribution is based on a part of the IRS Code that provides tax advantages. Pre-tax Contributions are deducted from your pay before taxes are calculated. This means that your taxable income is reduced and you pay less tax. Because some contributions are on a pre-tax basis, paychecks will show actual pay and Taxable Pay. Your actual pay is the Gross Pay you earned in the given pay period. Your Taxable Pay is the amount remaining from your Gross Pay, after any pre-tax deductions.

The following example shows how your take-home pay may be affected by Pre-tax Contributions to benefit plans (such as contributions for medical or dental benefits). With deductions taken on a pre-tax basis, take-home pay increases. Your actual savings will depend on several personal factors including your tax status, benefit coverage and, in some cases, where you live.

After-Tax Contributions	
Gross Pay	**$25,000**
Taxable Pay	**$25,000**
Federal Taxes	-1,665
State Taxes	-898
Social Security	-1,913
Benefit Contribution	-2,838
Annual Take-home Pay	**$17,686**

Pre-tax Contributions	
Gross Pay	**$25,000**
Benefit Contribution	-2,838
Taxable Pay	**$22,162**
Federal Taxes	-1,239
State Taxes	-735
Social Security	-1,695
Annual Take-home Pay	**$18,493**

When Social Security taxes are reduced, future benefits from Social Security will be slightly lower. In general, the reduction in benefits is very small and is offset by the increase in take-home pay. If you earn more than the Social Security taxable wage base, neither contributions nor benefits are affected. Benefits under Life Insurance and Long Term Disability are not affected by Pre-tax Contributions.

If you are covering a domestic partner, deductions from your paycheck for a domestic partner are deducted on a pre-tax basis and contributions the Company makes on behalf of your domestic partner and the taxability of your contribution for your domestic partner are imputed as income.

If you enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. The form must be completed before your enrollment request will be considered.

Contributions During a Leave of Absence

Circuit City realizes that Associates may be faced with conditions beyond their control, such as personal or family emergencies, that may require a leave of absence. In accordance with the Associate Leave Standard Operating Policy, benefit coverage will remain in effect during any absence provided that required contributions are made. If you are not Actively at Work or you are on a leave of absence, your contributions will be automatically taken from your check. If you do not receive a check, then deductions will be taken when you return to work. Upon returning to work, one regular deduction and one make up deduction will be taken out of each paycheck until your overdue balance is paid off.

If you are unable to return to work, you will be contacted regarding the outstanding contribution balance. If the balance is not paid, your coverage will be terminated back to the last day coverage was paid for.

When you take a leave of absence, information is mailed to you at your home address on file with the Associate Service Center. It is important to keep your personal information updated. Log on to www.mycircuitcityhr.com or call, write, fax or email changes to your contact information such as phone number and address changes.

Call the Associate Service Center at (800) 288-6353 if you have questions about paycheck deductions.

Claims

Filing a Claim

When you must file your own claims, submit the appropriate claim form(s) and supporting documentation to the address listed within each Plan's section in this booklet. Each Plan allows a specific amount of time for submitting and reviewing claims or appeals. Should the reviewer require additional information from you and/or other sources, you will be notified within the time period for that particular decision.

Refer to each Plan's section in this booklet for specific information about where, when and how to file claims.

When filing a claim, always include:

- The covered Associate's name, address and telephone number
- All information from the covered Associate's ID card as it appears
- The name of the person for whom the claim applies
- The date of service
- The name and contact information for the provider and place of service
- Description of the service and the charge for the service
- Statement of opinion as to why the denial was improper
- A copy of the EOB (if applicable)

If you do not hear from the reviewer within the timeframes noted within each Plan, you should assume your claim is denied and you should begin the appeal process. You may authorize a representative to act on your behalf if you are unable to file a claim or an appeal.

Obtaining and Submitting Information Related to Claims

During the claims review process, the Plan will:

- Provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- Permit you to submit written comments, documents, records and other information relating to the claim;
- Provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination;
- Provide a review that does not afford deference to the initial claim determination and that is conducted by a Plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person); and

- For Medical Plan claims, if the decision is based on a medical judgment:
  - The reviewer will consult with a health care professional with experience in the appropriate field;

- Ensure that any health care professional consulted during the review is someone other than the person consulted in the initial claim determination (or a subordinate of that person).

Denied Claims

If a Plan denies your claim in any way, you will be sent a notice of denial that includes the following information:

- The specific reason(s) for the denial with reference to specific provisions of the Plan on which the denial is based;
- A description of any additional material or information necessary to complete the claim and why that material or information is necessary;
- A description of the Plan's appeal procedures and time limits applicable for those procedures, including a statement of your rights in the event your claim is denied upon appeal;
- For Disability or health claims, a description of any internal rule, protocol or similar guideline that was used when making the determination of your claim, or a statement that such description will be provided to you at no charge upon request; and
- For Disability or health claims, if the denial was based on medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, or a statement that such explanation will be provided to you at no charge upon request.

Filing an Appeal

Your appeal should be made in writing and should include information directly related to the claim including:

- Your name and address
- Your Social Security number and that of the person for whom you are filing a claim
- Your account number for the particular Plan
- A statement of why you are appealing the denied claim
- The date of the initial notice of denial
- The date of service or incident for the claim that you are appealing

Denied Appeals

If a Plan denies your claim upon appeal, you will be sent a notice of denial that includes the following information:

- The specific reason(s) for the denial with reference to specific provisions of the Plan on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim;
- An explanation of any additional appeal procedures and a statement of your right to sue under ERISA following exhaustion of the Plan's claims and appeal procedures;
- For Disability or health claims, a description of any internal rule, protocol or similar guideline that was used when making the determination of your claim, or a statement that such description will be provided to you at no charge upon request; and
- For Disability or health claims, if the denial was based on medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, or a statement that such explanation will be provided to you at no charge upon request.

Administrative Note

The Plan administrator shall have discretionary authority to interpret the terms of the Plan and to decide factual and other questions relating to the Plan and Plan benefits including, without limitation, questions relating to eligibility for, entitlement to, and payment of benefits. Decisions of the Plan administrator are binding unless determined to be arbitrary and capricious.

Continuation of Coverage (COBRA)

If coverage for you and/or your Dependents ends, eligibility to continue coverage may apply. Optional continuation of group health coverage is available as a result of Public Law 99-272 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may continue Medical, Dental, Vision and/or Health Care Spending Account coverage.

COBRA Eligibility

If your employment ends for any reason, including retirement, or your hours worked are reduced so that coverage terminates, you and/or your covered Dependents may continue receiving benefits under the Medical, Dental Care, Vision Care and Health Care Spending Account Plans for up to 18 months. In the case of a Part-time Associate whose coverage has been terminated for non-payment, COBRA coverage may not be offered.

A newborn or newly Adopted Child who is added to a COBRA Participant's coverage has the right to COBRA coverage for the remaining period of the parents' COBRA coverage.

Election to continue coverage must be made within 60 days of the later of:

- The date coverage ends, or
- The date the COBRA qualifying event notice is given.

Under COBRA, you or a family member must notify the COBRA administrator within 60 days of the date of a Qualifying Family Status Change such as divorce, legal separation or when a Dependent no longer qualifies as a covered Dependent under the Medical, Dental Care, Vision Care or Health Care Spending Account Plans.

If you experience a Qualified Family Status Change or become entitled to Medicare, covered Dependents may continue coverage under the Medical, Dental Care, Vision Care or Health Care Spending Account Plans for up to 36 months. Covered children may continue coverage under the Medical, Dental Care and Vision Care Plans for up to 36 months after they no longer qualify as covered Dependents.

The COBRA administrator may send you a notice when you or your covered Dependents become entitled to continue coverage under the Plan. It is important for you to keep your personnel records up to date with your correct, current address.

Costs for COBRA

Anyone who elects to continue coverage with the Medical, Dental Care, Vision Care and/or Health Care Spending Account Plan(s) must pay the full cost of coverage (including the share paid by the Company), plus any additional amounts permitted by law.

If benefits are continued under a provision of the Plan, then those benefits will run concurrently with the benefits provided under COBRA.

Social Security and COBRA

If you or your covered Dependents are Totally Disabled, as certified by the Social Security Act, before or during the first 60 days of the initial COBRA coverage, you or that Dependent may continue coverage under the Medical, Dental Care, Vision Care and/or Health Care Spending Account Plan(s) for up to 29 months. If you become entitled to the Disability extension and have able-bodied Dependent(s) who is/are also entitled to COBRA, those family members who are not disabled are also entitled to the 11-month Disability extension. You must inform the COBRA administrator of your eligibility for the extended coverage before the end of the 18-month COBRA continuation period, and within 60 days of the date Social Security determines you to be disabled.

After the initial 18 months of COBRA coverage, coverage continues at an increased cost. Extended coverage continues only as long as the individual is disabled. The extended coverage ends in the month that begins 30 days after Social Security determines the Disability has ended. Extended coverage will not continue beyond 29 months unless a Qualified Family Status Change applies.

When COBRA Ends

Continued coverage, as specified above, ends when one of the following occurs:

- The cost of continued coverage is not paid when it is due
- The Participant becomes entitled to Medicare
- The Participant becomes covered under another group health plan that does not have an applicable Pre-existing Condition limitation
- Termination of the right to continue COBRA coverage
- The Company no longer provides the group health plan
- For the 11-month extension, in the case of Disability, if the Participant is no longer disabled before the end of the 11-month extension

Associates or eligible Dependents who elect COBRA coverage will receive a Certificate of Creditable Coverage when their COBRA coverage ends.

Your COBRA Rights Notice

Continuation Coverage Rights Under COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the other relevant provisions of this Summary Plan Description or contact the Plan administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified Beneficiary." You, your spouse, and

your Dependent children could become qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Associate of Circuit City, you will become a qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- *Your hours of employment are reduced, or*
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified Beneficiary if he/she lose coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B and/or Part D); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-associate dies;
- The parent-associate's hours of employment are reduced;
- *The parent-associate's employment ends for any reason other than his or her gross misconduct;*
- The parent-associate becomes entitled to Medicare benefits; or
- The parents become divorced or legally separated.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified Beneficiaries only after the Plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Associate, or the Associate's becoming entitled to Medicare, the employer must notify the third party administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the Associate and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?
Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified Beneficiaries. Each qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Associate, the Associate becomes entitled to Medicare benefits, your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Associate's hours of employment, and the Associate

became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Associate becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Associate's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The Disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Associate or former Associate dies, becomes entitled to Medicare benefits, or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to:

Associate Service Center
P.O. Box 563986
Charlotte, NC 28256-3986
Phone: (800) 288-6353

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan administrator.

Your Rights

As a Participant in a Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA states that all Plan Participants shall be entitled to the following rights and protections. The Circuit City Medical, Dental Care, Vision Care and Flexible Spending Account plans are considered ERISA plans. All other plans are not applicable to ERISA rights.

Information about Your Plan and Benefits

You may examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

You may obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The administrator may charge a reasonable amount for the copies. You may receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report (SAR).

Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. All administrative appeals must be exhausted before you may file suit in court.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Associate Service Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Special Rights under the Medical Plans

Newborns' and Mothers' Health Protection Act of 1996

This Act, an amendment to the Employee Retirement Income Security Act of 1974 (ERISA), requires that health plans provide coverage for childbirth Hospital stays for the mother and newborn child for:

- 48 hours following a vaginal delivery, or
- 96 hours following a delivery by cesarean section.

The mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- Prostheses and treatment of physical complications during all stages of the mastectomy, including lymphedemas.

Coverage for these services is subject to annual Deductibles and Coinsurance provisions just like other medical and surgical services covered under the Medical Plan.

Notice of Privacy Practices

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice applies to you if you are covered by the Circuit City Stores, Inc. Health Care Plan (the "Health Care Plan"), the Circuit City Stores, Inc. Traditional Dental Care Plan (the "Dental Plan"), the Circuit City Stores, Inc. Vision Care Plan (the "Vision Plan"), and/or the Circuit City Stores, Inc. Health Care Spending Account ("HCSA") as an Associate, former Associate or Dependent. This notice is intended to apply to the Health Care Plan, Dental Care Plan, Vision Care Plan and HCSA (hereafter collectively referred to as the "Plan").

It is the Plan's policy to maintain the privacy of protected health information in accordance with a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulates "covered entities" such as health plans, doctors and Hospitals. HIPAA does not regulate employers or non-health benefit plans such as Workers' Compensation, Disability, or life insurance plans. State law may impose limitations on the use and disclosure of your health information in addition to those imposed by HIPAA. The Health Privacy Project of the Institute for Health Care Research and Policy at Georgetown University maintains information on state health privacy laws at its website, www.healthprivacy.org.

Uses and Disclosure of Protected Health Information

"Protected health information" is information relating to your health condition or your receipt of health care, if it contains sufficient data to identify you as the subject of the information. Health information that is merely in summary form and that does not identify you as its subject is not protected health information and may be used or disclosed by the Plan

and/or the Company without restriction. For example, the Company may use aggregated data regarding claims paid for all Plan Participants to help project benefit costs for the next year.

The Plan may use or disclose protected health information without your specific authorization for treatment, payment and health care operations. Each of these terms has the following meanings:

- **"Treatment"** means the provision, coordination or management of health care, and related purposes. For example, the Plan may disclose protected health information to your doctor and his/her staff, the Plan's third party administrator and its staff, and other appropriate persons to help provide you with appropriate medical treatment.
- **"Payment"** means any actions undertaken by the Plan to obtain premiums, to determine responsibility for providing coverage, or to obtain or provide reimbursement for the health care services you receive. This includes, but is not limited to, eligibility and coverage determinations, billing, claims management and processing, Plan reimbursement, reviews for medical necessity, utilization review, and pre-authorization for treatment. For example, the Plan may disclose to your doctor and his/her staff, the Plan's third party administrator and its staff and other appropriate persons information concerning a particular medical procedure that you have had performed to determine whether the procedure is covered by the Plan.
- **"Health care operations"** means all the activities involved in the administration of the Plan. This includes, but is not limited to, quality assessment and improvement, evaluating providers, underwriting and other activities relating to obtaining or amending insurance contracts, disease management, cost management, and other general administrative activities. For example, the Plan may use information about you to refer you to a disease management program, to evaluate the quality of care you are receiving from your providers, or to project benefit costs and determine premiums.

Permitted disclosures include disclosures of protected health information between the Health Care Plan, Dental Care Plan, Vision Care Plan and HCSA, as well as disclosures to appropriate persons outside the Plan, when necessary for the Plan's treatment, payment or health care operations.

Protected health information may, in certain circumstances, be disclosed to Circuit City personnel who are involved in the administration of the Plan. These disclosures will be made in connection with Circuit City's role as the sponsor of the Plan, and will be made to enable Circuit City personnel to carry out their duties in administering the Plan. In many circumstances, it will be appropriate for such personnel to share protected health information with the Plan's business associates outside of Circuit City. Business associates include the Plan's third party administrators, lawyers, accountants, consultants and other appropriate persons.

In addition, the Plan may disclose protected health information to Circuit City or its business associates without your specific authorization so that Circuit City may obtain bids or modify or terminate the Plan. Information provided to Circuit City for these purposes will be in summary form. This means that the information will be limited to claims history, claims expenses, or types of claims experienced, with certain types of information removed. The Plan may also disclose Plan enrollment and disenrollment information to Circuit City without your specific authorization.

The Plan may use or disclose protected health information without your specific authorization for several other reasons, such as for public health purposes, auditing purposes, research studies, health oversight activities, certain judicial or administrative proceedings, emergencies, and when otherwise required by law. For example, the Plan may be required to disclose protected health information to law enforcement officials in specific circumstances or to the U.S. Department of Health & Human Services, which monitors compliance with the HIPAA regulations.

Other Uses and Disclosures

The Plan may disclose protected health information without your written authorization to your family member, friend, or other person identified by you if the information directly relates to that person's involvement with your care or payment for your care, or if the disclosure is necessary to notify the family member or other individual of your condition or your location. In such cases, you will be given an opportunity to agree or object to the disclosure, if you are able to do so.

HIPAA permits other incidental uses and disclosures that occur as a by-product of a permissible or required use or disclosure. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by HIPAA. The Plan has adopted reasonable safeguards to protect against uses and disclosures not permitted by HIPAA and to limit incidental uses or disclosures. However, those safeguards cannot guarantee the privacy of protected health information from any and all potential risks. In implementing safeguards, the Plan has considered the nature of the protected health information held, the potential risks to privacy, the potential effects on patient care, and the financial and administrative burden of particular safeguards. The Plan is not required to obtain your authorization or notify you if an incidental disclosure occurs.

Where use or disclosure is not otherwise permitted under the HIPAA regulations, the Plan will ask for your written authorization before using or disclosing protected health information. For instance, as a condition of your participation in Circuit City's Short Term Disability Plan, you will be required to give your written authorization for the Plan to disclose protected health information to the Short Term Disability Plan administrator so that it may make coverage or benefit determinations under that plan. In addition, the Plan will ask for your written authorization before using or disclosing notes about you from your psychotherapist. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop future uses and disclosures, except to the extent the Plan has acted in reliance upon your authorization. If the authorization was required as a condition of your participation in any other benefit plan sponsored by Circuit City, your revocation may affect your eligibility for such other plan.

Individual Rights

You have the right to review and receive copies of your protected health information maintained by the Plan in a designated record set or used by the Plan to make decisions about your coverage or benefits. A "designated record set" means the enrollment, payment, claims adjudication, and case or medical management records maintained by the Plan. If you request copies of this information, you will be charged 5 cents for each page. Your request should be made in writing to the Associate Service Center, and the Plan will comply with the request within 30 days of your request (60 days if the information is maintained offsite), subject to a possible additional 30-day extension. If your request is denied, you will receive a written explanation of the reasons for the denial.

You have the right to receive a list of instances where the Plan or employer has disclosed your protected health information to third parties after the effective date of this notice for reasons other than treatment, payment or health care operations, except in cases where you have authorized the disclosure, the disclosure was merely incidental to a disclosure that is otherwise permitted under this privacy policy, or the disclosure was required for law enforcement or national security purposes. You may request one such list at no charge every 12 months. For any additional requests, you will be charged 5 cents per page.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that the Plan correct existing information or add missing information. Your request should be made in writing to the Associate Service Center. The Plan has 60 days to respond to your request, subject to a possible additional 30-day extension. If your request is denied, you will receive a written explanation of the reasons for the denial.

You may request in writing to the Associate Service Center that the Plan not use or disclose your protected health information for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. You may also request restrictions on disclosures to your family members or other individuals who are involved in your care or payment for your care. The Plan will consider your request, but is not legally required to accept it. The Plan will also accommodate reasonable requests to receive communications of protected health information at alternate locations or by alternate methods, if the normal method of communication could endanger you.

You may request a written copy of this notice at any time by contacting the Associate Service Center.

The Plan's Legal Duties

HIPAA requires the Plan to maintain the privacy of protected health information, to provide this notice about its information practices, and to follow the practices that are described in this notice. The Plan may change its privacy policies at any time, and changes may apply to all protected health information held by the Plan at the time of the change. When the Plan makes a significant change in its policies, a revised Notice of Privacy Practices will be distributed to all current Plan Participants within 60 days of the change. This notice and Circuit City's privacy policies do not create any legal rights, contractual or otherwise, under state or federal law, but simply give you notice of the Plan's obligations under HIPAA and your rights under HIPAA.

Complaints

If you are concerned that the Plan has violated your privacy rights, or you disagree with a decision made about access to or amendment of your health records, you may contact the Associate Service Center. You may also send a written complaint to:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Neither the Plan nor Circuit City may retaliate against you in any way for exercising your right to file a complaint.

Contact Information

For more information on the Plan's privacy practices, you may contact the Associate Service Center at:

Associate Service Center
P.O. Box 563986
Charlotte, NC 28256-3986
(800) 288-6353

This notice is effective as of April 14, 2003 and as amended March 1, 2005.

Terms and Conditions

Your completion of any enrollment process indicates your understanding and acceptance of each of the Terms and Conditions as follows:

1. You have reviewed the appropriate material and understand any Plan changes or provisions described therein. You understand that you should refer to the appropriate sections of this Summary Plan Description for more information concerning the eligibility, services, limitations and conditions of each Plan or program.

2. You understand that if you are enrolling in a Plan or program for the first time, your benefits may be limited as subject to specific Plan provisions or you may be required to provide additional documentation before your enrollment is accepted.

3. You understand that if you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your Dependents in the Medical, Dental Care and/or Vision Care Plans, as well as the Health Care and Dependent Care Savings Accounts provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself as well as your Dependents in the Medical, Dental Care and/or Vision Care Plans, as well as the Health Care and Dependent Care Savings Accounts provided that you request enrollment within 30 days of the event. (A new dependent may also be added in accordance with the Qualified Family Status Change rules summarized in the "Changing Your Election" portion of this Summary Plan Description.)

4. You understand that once you are enrolled, you cannot drop or change your coverage/contributions until the next annual enrollment, unless you experience a Qualified Family Status Change.

5. Your deductions/contributions for the Medical, Dental Care, Vision Care, Dependent Care Spending Account and Health Care Spending Account will be made on a pre-tax basis. If you are covering a domestic partner, deductions will be made on a pre-tax basis; however, your deductions and the contributions the Company makes on behalf of your domestic partner are imputed as income.

6. Your deductions/contributions for the Supplemental Life, Spousal Life, Child Life, Accidental Death & Dismemberment, and/or Long Term Disability Plans will be made on an after-tax basis. You authorize the Company to make all required payroll deductions for the benefits you have elected.

7. If the dollar amount necessary to cover the required deductions for the coverage you elect is increased or decreased during the Plan Year, you understand that your deductions will automatically be adjusted to reflect the increase or decrease.

8. Where applicable, you agree to assist in the recovery of any benefits paid by these Plans or programs which were also paid by a source other than one of these Plans or programs to yourself and/or your Dependent(s), including payments made as a result of claims or suits against a third party.

9. You understand that coverage and/or enrollment for yourself and/or your Dependents may be terminated for falsification, fraud or deception by representation or omission in requesting benefits under these Plans, misrepresenting eligibility under these Plans or knowingly permitting such falsification, fraud, deception or misrepresentation by another.

10. You must complete an electronic enrollment process during the designated eligibility or annual enrollment period.

Medical Plans

Empire Medical Plan

Empire BlueCross BlueShield PPO
(800) 675-1277
www.empireblue.com/circuitcity

With the Medical Plan, administered by Empire BlueCross BlueShield, you do not have to choose a primary care Physician. You receive maximum benefits, low Coinsurance and low Copayments when you use Health Care Providers who participate in the extensive nationwide BlueCross BlueShield network. Additionally, you benefit from coverage offered through Medco Health Solutions Prescription Drug Program and Anthem's Behavioral Health Program.

The most important benefit of this Plan is the protection it provides you and your family against unexpected medical expenses.

Circuit City wants to provide comprehensive benefits for its Associates; therefore, your contributions to the Medical Plan are supplemented by contributions made by the Company. Costs vary by your type of coverage. Your Pre-tax Contributions* are deducted automatically from each paycheck.

The overall cost of the Medical Plan, including both Company and Associate contributions, is based on actual medical expenses for all Participants. Because the cost of coverage is directly related to the amount of claims, it is important to maintain a healthy lifestyle, avoid unnecessary treatments and keep informed about the services you receive. For a list of current monthly Associate contributions, visit www.mycircuitcityhr.com.

**If you are covering a domestic partner, deductions from your paycheck for a domestic partner are deducted on a pre-tax basis and contributions the Company makes on behalf of your domestic partner and the taxable amount of your contribution for your domestic partner are imputed as income.*

For information regarding programs and discounts available under the Empire medical plan, refer to the "Other Discounts and Programs" section at the back of the guide.

Eligibility and Enrollment

Associate Eligibility

Regular Full-time Associates are eligible for coverage under this Plan the first of the month after completing one calendar month of service.

Dependent Eligibility

Regular Full-time Associates may cover eligible Dependents, including spouse, domestic partner and eligible Dependent children.

If you want to enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. The form must be completed before your enrollment request will be considered. If your claim

initiation/appeal to add coverage after the eligibility timeframe is approved, your benefit deductions will be taken on an after-tax basis for the remainder of the Plan Year.

How and When to Enroll

If you are a Regular Full-time Associate, you must complete the on-line enrollment process within 30 days after your date of hire, during annual enrollment or upon/after a Qualified Family Status Change.

Types of Coverage

When you enroll, select your type of coverage depending on the number of eligible individuals to be covered.

TYPE OF COVERAGE	ELIGIBLE INDIVIDUALS
Associate	Associate only
ciate and Child(ren)	Associate and eligible Dependent child(ren)
ciate Spouse or domestic partner	Associate and spouse or domestic partner only
	Associate and spouse or domestic partner and one or more eligible Dependent child(ren)

Call the Center at (800) 288-6353 for questions about eligibility and enrollment.

ID Cards

After the effective date of coverage, you will receive one Medical ID card and one Prescription Drug ID card for Associate only coverage. For all other types of coverage, you will receive two Medical ID cards and two Prescription Drug ID cards with the covered Associate's name on them. Medical and Prescription Drug ID cards give you and your Dependents access to Health Care Providers and pharmacies throughout the United States.

Always show your ID card to your Health Care Provider or pharmacist to receive full Plan benefits.

If you or your Dependents need medical services after the effective date coverage begins, but before receiving ID cards, you can download a temporary medical ID card from www.empireblue.com/circuitcity and a temporary prescription ID card from www.medcohealth.com. With the temporary ID card, many Health Care Providers/pharmacies will submit claims for you. If the Health Care Provider/pharmacy will not submit your claim, you will need to submit the claim for reimbursement. Refer to the section titled "Claims" for more details and submission timelines.

Medical ID Cards and Claim Forms	Empire Customer Service (800) 675-1277 or www.empireblue.com/circuitcity
Prescription Drug ID Cards and Claim Forms	Medco Health Solutions Member Services (800) 988-4105 or www.medcohealth.com

Empire Website

Empire has a comprehensive website with tools and resources to help you manage your health. You can access your explanation of benefits (EOBs), temporary ID cards, claims history, network directory, as well as a treatment cost advisor to help you estimate your costs for a particular service. Simply log on at www.empireblue.com/circuitcity to access these resources provided by Empire.

Terms to Know

Your coverage with the Medical Plan takes into account several factors when determining the expense to you. As you review coverage and expenses, it will help to know the terms listed below. Additional important terms found throughout this Medical Plan section are defined in the Glossary at the back of this booklet.

- **Coinsurance** – The percentage amount of the charge for Covered Services and supplies that you must pay after the Deductible is met. The Plan typically pays the remaining percentage of the Covered Expense.
- **Copayment** – Set dollar amount paid by you or your Dependents for specific services received. Copayments apply on a per-visit, per-patient basis. Copayments do not accumulate toward the annual Out-of-Pocket Maximum and continue to be charged after the annual Out-of-Pocket Maximum has been satisfied.
- **Covered Services** – Those services for which the Plan will pay a portion of the cost.
- **Maximum Benefit** – A cap on the amount of expenses that the Plan pays for your health care. The Plan allows a maximum lifetime benefit of $1,500,000 per covered individual. Other maximums for certain services and supplies may apply.
- **Network Provider** – A Health Care Provider who belongs to Empire BlueCross BlueShield's PPO Program. You receive maximum benefits by going to Network Providers, versus Non-network Providers who are not part of BlueCross BlueShield. Network Providers file claims on behalf of covered Participants. In most cases, services provided by Physicians on staff at a Network Hospital will be paid as though those Physicians are Network Providers. This payment provision also applies to non-physician Health Care Providers if their profession is not contracted by BlueCross BlueShield, such as Nurse Midwives and Nurse Practitioners.

Call (800) 675-1277 or go to www.empireblue.com/circuitcity to find Network Providers in your area.

- **Out-of-Pocket Maximum** – A cap on the amount of expenses that you pay for Covered Services, not including Deductibles and/or Copayments.
- **Plan Year Deductible** – Amount you must pay for certain Covered Expenses before the Plan begins to pay benefits for that service(s). The Plan Year Deductible does not take into account payments you and/or your covered Dependents make toward Copayments and/or special Deductibles.
  - With Associate only coverage or Associate and spouse/domestic partner coverage, each Participant must meet the Deductible separately each Plan Year.
  - With family or Associate and children(ren) coverage, the combination of expenses for all Covered Family Members applies toward meeting the Deductible. However, each person will not exceed the individual deductible of $500.
- **Reasonable & Customary Charges** – Equal to 150% of the Medicare allowance rate.
- **Special Deductible** – A $500 fee applied, per person, per incident, when unauthorized services are received by you or your covered Dependents. Special Deductible fees do not count toward any other Deductible or the Out-of-Pocket Maximum.

Pre-existing Conditions

Defining the Pre-existing Condition Exclusion Period

A Pre-existing Condition is any physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months prior to your Enrollment Date. A Pre-existing Condition Exclusion Period may apply. The exclusion period is for 12 months after your enrollment date where expenses and benefits related to a Pre-existing Condition are excluded from coverage.

- If you enroll when you are first eligible, your eligibility Waiting Period will be applied to the 12-month exclusion period.
- If you enroll after your eligibility Waiting Period, the full 12-month Pre-existing Condition Exclusion Period applies.

During the Pre-existing Condition Exclusion Period, your claims may be subject to review to determine if the condition you are filing a claim for qualifies.

If you and/or your Dependents provide evidence of Creditable Coverage for a period prior to your Enrollment Date, the Pre-existing Condition Exclusion Period may be reduced or not apply. Creditable Coverage is proof that you and/or your Dependents were covered under another health plan. The time you were covered under the other plan may count toward your Pre-existing Condition Exclusion Period. This may satisfy the Pre-existing Condition exclusion as long as you did not have a lapse in coverage for more than 63 continuous days. The Waiting Period between the first of the month after you are hired and when you are eligible to enroll is not included in any lapse of coverage.

Example: If you were covered by another health plan for five months prior to your Waiting Period (the calendar month before your eligibility date), that time may be eligible for Creditable Coverage and may apply to the Pre-existing Condition Exclusion Period. With Creditable Coverage for those five months, only services received in the first seven months of your coverage with the Plan will require review to determine if the services are for a Pre-existing Condition. After the last day of the seventh month, coverage will apply without regard to Pre-existing Conditions.

If you or an eligible Dependent have Creditable Coverage from a previous health care plan, a Certificate of Creditable Coverage should be sent to you automatically. If necessary, call the Associate Service Center at (800) 288-6353 for additional information about obtaining a Certificate of Creditable Coverage.

The Pre-existing Condition Exclusion Period does not apply to any new Participant who was covered under another medical plan for at least 12 continuous months immediately prior to enrolling in this Plan.

Determining a Pre-existing Condition

When the Plan receives a claim from your Health Care Provider during the Pre-existing Condition period, a Plan representative may send a letter to the provider (and a copy to you) requesting additional information in order to determine if the claim is related to a Pre-existing Condition. Once the provider sends the requested information, the Plan will review the response and determine if the claim is payable.

If the services were for a Pre-existing Condition, payment will not be made for those services. Non-covered services and the cost of those services will not count toward meeting your Deductible and Out-of-Pocket Maximums. However, if the services were to treat a condition that was not considered pre-existing; the appropriate payment will be made.

Services that are not considered Pre-existing Conditions include Covered Services for pregnancy and for newborns, Adopted Children and/or children placed for adoption if they are enrolled within 60 days from the birth, adoption or placement for adoption.

Prior Authorization

Whenever you plan to seek medical services, fill a prescription or receive treatment for mental health or substance abuse, it is best to consult the Plan to make sure a prior authorization is not required. By obtaining prior authorization, you help ensure that you will receive maximum benefits under the Plan.

If you receive services that require prior authorization and you fail to obtain the authorization, you may have to pay a $500 Special Deductible for each unauthorized service or treatment.

Medical Services Prior Authorization

For specific guidelines about obtaining prior authorization for medical services, refer to the section of this Plan titled "Medical Management." When you have questions about prior authorizations or you need to request a prior authorization, call Empire at (800) 675-1277 and select the prompt for Medical Management.

Behavioral Health Prior Authorization

All mental health and substance abuse treatments require prior authorization. In some cases, a series of treatments is authorized through one contact with Anthem. This is called a concurrent claim. Whether you require one visit, an extended visit or ongoing therapy, Anthem will work with you, your Health Care Provider and Case Manager to determine the best course of action and authorization.

- If you do not receive authorization prior to admission to a Hospital, psychiatric or substance abuse Treatment Center (by the next business day after emergency treatment), a special Deductible of $500 applies.
- If you do not receive authorization prior to receiving outpatient treatment or do not follow an authorized treatment plan(s), benefits will be reimbursed at the out-of-network benefit level.

Prescription Drug Prior Authorization

In certain instances, prior authorization is required before filling a prescription. Your pharmacist will notify you in that case. For a prescription drug prior authorization, the pharmacist or doctor may initiate the review process by calling a special toll-free phone number. Reviews typically take two business days. The patient and Physician will be notified *when the review process is complete.*

- If your medication is approved, it will be covered under standard Plan guidelines.
- If it is not approved, you will have to pay the full cost of the prescription if you decide to fill it.

Below is the contact information for prior authorization:

Medical Services Prior Authorization	Behavioral Health Prior Authorization	Prescription Drug Prior Authorization
Medical Management (800) 675-1277 *Select the appropriate prompt for your inquiry.*	Anthem Behavioral Health (800) 675-1277 *Select the appropriate prompt for your inquiry.*	Medco Health Solutions (800) 988-4105 *Select the appropriate prompt for your inquiry.*

Medical Plan Highlights

The Medical Plan covers a wide range of medical services called Covered Services. With the Empire BlueCross BlueShield Preferred Provider Organization (PPO), you and your Dependents receive the most cost-efficient treatment available, including a number of special features to help you make informed choices about your health care. Unlike many complicated medical plans, our Plan makes accessing your health care easy.

You do not have to select a primary care Physician.

When you visit a doctor, primary care Physician or specialist, you pay for the visit with a Copayment. If, while you are there, you undergo any procedures that are not included in the office visit, the fees for those procedures may be subject to the Deductible and Coinsurance, i.e. a percentage of the expenses for the service(s).

The Medical Plan includes a Prescription Drug Program and a Behavioral Health Program for enrolled Participants.

Plan Provisions and Maximums

PLAN PROVISION	IN-NETWORK *You Pay*	OUT-OF-NETWORK *You Pay*
Plan Year Deductible	$500 for Associate only coverage $1,000 for all other coverage levels	$1,000 for Associate only coverage $2,000 for all other coverage levels
Plan Year Coinsurance Out-of-pocket Maximum	$2,000/Associate $4,000/Associate plus spouse/domestic partner $4,000/Associate and plus children $5,000/Associate and family	$3,000/Associate $6,000/Associate and plus spouse/domestic partner $6,000/Associate and plus children $9,000/Associate and family
Maximum Lifetime Benefit (Per Person, In- and Out-of-network combined)	$1,500,000	$1,500,000
Out-of-network and Network Plan Year Deductibles and Out-of-Pocket Maximums accumulate separately. Covered Expenses applied toward the network Deductibles and Out-of-Pocket Maximums do not satisfy Non-network Deductibles and Out-of-Pocket Maximums, and vice versa.		